Cheryl Roberts
ACTING DIRECTOR

Department of Medical Assistance Services

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

January 1, 2023

Virginia Medical Assistance Eligibility Manual
Transmittal #DMAS-26

The following acronyms are contained in this letter:

- COVID – Coronavirus Disease
- DMAS – Department of Medical Assistance Services
- DOC – Department of Corrections
- FC – Foster Care
- IMD – Institution for the Treatment of Mental Diseases
- LDSS – Local Department of Social Services
- LIFC – Low Income Families with Children
- LTSS – Long-term Services and Supports
- MAGI – Modified Adjusted Gross Income
- NABD – Non-Aged, Blind or Disabled
- PHE – Public Health Emergency
- TN – Transmittal

TN #DMAS-26 includes policy clarifications, updates and revisions. Unless otherwise noted in the Cover Letter and/or policy, all provisions included in this transmittal are effective with eligibility determinations and post-eligibility (patient pay) calculations made on or after January 1, 2023. Note that COVID-19 PHE guidelines continue until the emergency is over and are not referenced in Medical Assistance Eligibility Policy.

The following changes are contained in TN #DMAS-26:

Changed Pages	Changes
Subchapter M0130.200	Reasonable Compatibility income determination applies to applications, reapplications, case changes and renewals.

Changed Pages	Changes
Subchapter M0140.200	Clarifies that an approved offender is enrolled in full Medicaid upon release.
Subchapter M0220	Removes references to the requirement that certain non-citizens have 40 qualifying quarters of work history to be a "qualified alien."
Subchapter M0280.300	Clarifies offender status if in DOC CCAP program.
Chapter M03, Appendix 1	Updates contact information for DDS Regional office and remove individual office contacts.
Subchapter M0310	Modifies name of aid category of former foster care children and removes requirement to have been in FC in Virginia.
Subchapter M0320.203	Updates COLA and Medicare changes for 2023.
Subchapter M0330.220	Clarifies that if the individual's income exceeds the LIFC income limit, the individual is not eligible as LIFC. Individuals should then be evaluated as MAGI prior to extension evaluation.
Subchapter M0450.400	Clarifies that if the individual does not provide the necessary verifications for the gap-filling evaluation the application should be denied.
Subchapter M0530, Appendix 1	Updates the NABD deeming standard for 2023.
Subchapter M0810.002	Updates SSI amounts for 2023.
Subchapter M0820	Updates Student Earned Income Exclusion for 2023.
Subchapter M0830	Removes reference to SPARK; clarifies that SSA increase disregard applies to intake as well as ongoing evaluations. Adds reference to disregarding KinGap payments.
Subchapter M1110	Updates the MSP resource limits for 2023.
Subchapter M1420	Clarifies that an LTSS authorization is not required prior to determining financial eligibility using rules for institutionalized individuals. If the individual meets the definition of institutionalization they are evaluated using these rules.

Changed Pages	Changes
Subchapter M1450.830	Adds email address to send 225 to DMAS.
Subchapter M1460	Updates the home equity limit and Student Earned Income Exclusion.
Subchapter M1470	Updates the Special Earnings Allowance.
Subchapter M1480	Updates the home equity limit, the spousal resource standards, the maximum monthly maintenance needs allowance, the personal maintenance allowance, and the special earnings allowance.
Subchapter M1520	Clarifies that if ineligible for the Medicaid extensions, individuals must be evaluated for eligibility other covered groups (including MAGI) prior to medically needy evaluation. Also clarifies that an auxiliary grant (AG) case should be retained by the agency issuing the grant.
Subchapter M1850	Removes references to Medicaid co-pays.

Please retain this TN letter for future reference. Should you have questions about information contained in this transmittal, please contact Cindy Olson, Director, DMAS Eligibility and Enrollment Services Division, at cindy.olson@dmas.virginia.gov or (804) 225-4282.

Sincerely,

Sarah Hatton

Sarah Hatton, M.H.S.A.
Deputy of Administration

Attachment

Changed With	Effective Date	Pages Changed
TN #DMAS-26	1/1/23	Page 10
TN #DMAS-25	10/1/22	Pages 9,10
TN #DMAS-23	4/1/22	Pages 5, 12
TN #DMAS-21	10/1/21	Page 14
TN #DMAS-20	7/1/21	Page 2 Page 2a is a runover page.
TN #DMAS-18	1/1/21	Pages 4, 8, 13

from these available sources, including the VEC, may be used if the information is less than 12 months old. The agency must include in each applicant's case record facts to support the agency's decision on the case.

1. **Resources**

The value of all countable, non-excluded resources must be verified. If an applicant's attested resources are over the resource limit, the applicant or authorized representative must be given the opportunity to provide verification of the resources. All available resource verification system(s) must be searched prior to requesting information from the applicant.

2. **Use of Federal Income Tax Data**

The Hub provides verification of income reported to the IRS. Income information reported to the IRS may be used for eligibility determinations for Families and Children (F&C), MAGI Adults, and ABD covered groups when IRS information is available. The income reported on the application is compared to the data obtained from the Hub for reasonable compatibility per M0420.100. When IRS verification is used for an ABD individual, reasonable compatibility is acceptable as verification of earned (i.e. taxable) income.

Note: Reasonable compatibility applies to applications, reapplications *and renewals.*

3. **SSA Data**

Social Security and/or Supplemental Security Income must be verified through SSA. The Federal Hub links to SSA data. SOLQ-I may also be used. The State Data Exchange (SDX) system should only be used as an alternate method when the Hub or SOLQ-I is not available.

4. **Income**

For all case actions effective *August 26, 2022*, the applicant's attested income, including when the applicant attests to having zero ($0.00) income, is considered the verified income if the income attested to by the applicant is within 20% of the income reported by electronic data sources OR both sources are below the applicable income limit.

If the attested income is under the income limit and the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return. If the applicant meets a MN covered group, verification of income **is required** to determine spenddown liability based on actual income received.

For individuals requesting long-term services and supports (LTSS), verification of income is required to calculate the patient pay. See M1470.

If the attested income is over the income limit and the individual does not meet a Medically Needy (MN) covered group, deny the application.

If the individual agrees that the discovered countable income was received, determine if the on-line information can be used to evaluate current/ongoing eligibility. If the discovered information is not sufficient to evaluate eligibility, send a written request for needed verifications and allow at least ten calendar days for the return of the verifications.

If the individual reports the income has stopped, ask when the income stopped to ensure all income needed to correctly determine prospective and retroactive eligibility (if appropriate) is evaluated. Note the date of termination of income (last pay received) in the record. If the income stopped during a month that is being evaluated for eligibility, the individual must provide verification of the termination of income.

M0140 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-26	1/1/23	Page 3
TN #DMAS-25	10/1/22	Page 1, 3, 5
TN #DMAS-24	7/1/22	Page 3, 4
TN #DMAS-21	10/1/21	Page 1
TN #DMAS-18	1/1/21	Pages 3-5
TN #DMAS-14	10/1/19	Pages 4, 5

***C.* Offender Application Processing**

An application is not to be refused or denied because an applicant is incarcerated. A person is not required to have had an inpatient hospitalization in order to apply for Medicaid. The agency must evaluate the eligibility of all MA enrollees, with respect to circumstances that may change, at least every 12 months unless the enrollee is pregnant (see M1520.200 p.9).

1. New Application

An offender who does not have active Medicaid coverage may apply while incarcerated. Coverage is based on the month of application and can include up to three months of coverage (if requested) prior to the month of application, provided eligibility requirements are met.

Ongoing coverage in AC 108 or AC 109 is effective the first day of the month of application or the date when incarceration begins, whichever is later.

2. Re-entry Process

A medical assistance application for an offender with no active Medicaid coverage and an anticipated release date within 45 days is handled as part of a "Re-Entry" process and will follow the same procedure as a New Application (ref M0140.200.C.1). If the offender is approved the case will have a redetermination conducted for ongoing Medicaid coverage. This is a new application and an eligibility determination for Medicaid coverage will be made based on the information as reported or known at the time of release from the facility. *If approved the member will be enrolled upon release*.

If the person is approved but is unable to or does not provide a post-release address where he will reside (e.g. reports as homeless or moving to a temporary shelter) the case will be transferred to the LDSS of his pre-incarceration, if known. If there is no known address, or the individual lived outside of Virginia prior to incarceration and intends to remain in the state, transfer the case to the LDSS where the correctional facility is physically located.

If the application is approved the worker will confirm that a new Commonwealth of Virginia Medicaid Card has been generated and a copy of the Notice of Action sent to the anticipated post-release address.

3. Emergency Services

A non-citizen who meets all Medicaid eligibility requirements except for immigration status, and has received an inpatient hospitalization, may qualify for coverage of emergency medical care. This care must have been provided in a hospital emergency room or as an inpatient in a hospital. Determine eligibility for emergency services using policy in M0220.400 and enroll eligible individuals using the procedures in M0220.600 D.

For cases processed at the Cover Virginia Incarcerated Unit (CVIU) the individual will be enrolled in the appropriate AC 112 or AC 113 and the case will be retained at the CVIU for ongoing case maintenance.

Emergency Services coverage in AC 112 or AC 113 is effective the first day of the month of application, the first day of the retroactive period, or the date when incarceration begins, whichever is earliest.

M0220 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-26	1/1/23	Appendix 4 pages 2 and 3
TN #DMAS-25	10/1/22	Table of Contents, Page 14d. Page 22 Appendix 4 added page 2.
TN #DMAS-24	7/1/22	Table of Contents Pages 1, 4a, 4b, 5, 6a, 8, 14d, 14e, 15, 17, 18, 21, 22, 23 Page 6b was added as a runover page. Appendix 9 was added. Pages 22a and 24-25 were removed.

D. Information received through SVES will not report earnings for the current year nor possibly the last year's earnings (i.e. the lag period). The SVES report will also not include employment that is not covered under Social Security (i.e. not requiring payment of FICA/Social Security tax). The applicant must provide verification of earnings through pay stubs, W-2 forms, tax records, employer records, or other documents, if quarters of the lag period or non-covered employment are needed.

If the alien believes the information from SSA is inaccurate or incomplete, beyond the current two-year lag period, advise the applicant to provide the verification to SSA to correct the inaccurate income records.

In evaluating the verification received directly from the applicant or through SVES, **exclude** any quarter, beginning January 1997, in which the person who earned the quarter received benefits from the TANF, SSI, or Medicaid, or SNAP Programs or the food assistance block grant program in Puerto Rico.

E. In situations when consent to release information through SVES cannot be obtained from a parent or spouse, other than death, request information about quarters of coverage directly from the Social Security Administration. Complete or obtain from the applicant a Request for Quarters of Coverage (QC) History Based on Relation form, SSA-513. The form specify the period(s) for which the verification is requested. Submit the completed from to:

Social Security Administration
P.O. Box 33015
Baltimore, Maryland 21290-3015

F. When the SSA is unable to determine if a quarter should be allowed, the SVES inquiry will show "Z" or "#" codes. *The requirement for a 40-quarter work minimum was eliminated effective April 1, 2021.* Use Form SSA-512, "Request to Resolve Questionable Quarters of Coverage (QC)," to resolve quarters before 1978. A copy of the SVES report must accompany the completed form. Submit Form SSA-512 to:

Social Security Administration
Office of Central Records Operations
P.O. Box 33015
Baltimore, Maryland 21290-3015

For questionable quarters for 1978 *thru March 31, 2021,* the applicant must complete Form SSA-7008. "Request for Correction of Earnings." This form is available at local SSA offices. At the top of the form write "Welfare Reform." Submit the form and proof of earnings to:

Social Security Administration
Office of Central Records Operations
P.O. Box 30016
Baltimore, Maryland 21290-3016

II. Establishing Quarters:

The requirement for a 40-quarter work minimum was eliminated effective April 1, 2021. Use the following information to (1) determine whether the applicant's earnings as reported in section I.A were sufficient to establish quarters of coverage and (2) to determine the number of QQ during lag periods and when the reported employment is not a covered earning for Social Security reporting purposes:

- A quarter is a period of 3 calendar months ending with March 31, June 30, September 30 and December 31 of any year.

- Social Security quarters of coverage are credits earned by working at a job or as a self-employed individual. A maximum of four credits or quarters can be earned each year.

- For 1978 and later, credits are based solely on the total yearly amount of earnings. The number of creditable QQ are obtained by dividing the total earned income by the increment amount for the year. All types of earnings follow this rule. The amount of earnings needed to earn a credit increases and is different for each year. The amount of earnings needed for each credit and the amount needed for a year in order to receive four credits are listed below.

- A current year quarter may be included in the 40-quarter computation. Use the current year amount as the divisor to determine the number of quarters available.

If you need to use quarters before 1978:

- A credit was earned for each calendar quarter in which an individual was paid $50 or more in wages (including agricultural wages for 1951-1955);

- Four credits were earned for each taxable year in which an individual's net earnings from self-employment were $400 or more; and/or

- A credit was earned for each $100 (limited to a total of 4) of agricultural wages paid during the year for years 1955-1977.

Year	Increment Amount	Amount Required for 4 QCs
2013	$1,160	$4,640
2012	$1,130	$4,520
2010 – 2011	$1,120	$4,480
2009	$1,090	$4,360
2008	$1,050	$4,200
2007	$1,000	$4,000
2006	$970	$3880

M0280 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-26	1/1/23	Pages 6, 9
TN #DMAS-20	7/1/21	Table of Contents Page 1 Appendix 2 was added.
TN #DMAS-19	4/1/21	Pages 3, 4 Appendix 1 Page 4a was added.
TN #DMAS-17	7/1/20	Pages 7, 9, 10 Page 11 was deleted.
TN #DMAS-15	1/1/20	Page 9 Appendix 1
TN #DMAS-14	10/1/19	Pages 6, 7, 9, 11
TN #DMAS-2	10/1/16	Pages 7, 9
TN #100	5/1/15	Table of Contents Pages 1-11 Appendix 1 was added Pages 12 and 13 were deleted.
UP #9	4/1/13	Page 5
Update (UP) #7	7/1/12	Table of Contents Page 8 Appendix 1 was deleted.
TN #94	9/1/10	Page 1
TN #93	1/1/10	Page 13

M0280.300 INMATE OF A PUBLIC INSTITUTION

A. Policy

Inmates of public institutions fall into three groups:

- individuals living in ineligible public institutions;
- incarcerated adults; and
- juveniles in detention.

An individual is an inmate of a public institution from the date of admission to the public institution until discharge, or from the date of actual incarceration in a prison, county or city jail or juvenile detention facility *and considered* incarcerated until permanent release, bail, probation or parole. *An offender sentenced to the Community Corrections Alternative Program (CCAP) are confined in a DOC facility are not considered released, and are not a parolee or probationer.*

Incarcerated individuals (adults and juveniles) who are hospitalized can be eligible for Medicaid payment limited to services received during an inpatient hospitalization, provided they meet all other Medicaid eligibility requirements.

An individual released from jail under a court probation order due to a medical emergency is NOT an inmate of a public institution because he is no longer incarcerated.

B. Public Residential Facility Residents

An individual who lives in a public residential facility that serves more than 16 residents is NOT eligible for Medicaid.

A public residential facility that does not meet the definition of a "publicly operated community residence" in section M0280.100 above, is an "ineligible public institution."

The following are ineligible public institutions:

- public residential institutions with more than 16 beds
- residential facilities located on the grounds of, or adjacent to, a public institution with more than 16 beds:

D. Juveniles in Detention

In determining whether a juvenile (individual under age 21 years) is incarcerated, the federal Medicaid regulations distinguish between the nature of the detention, pre- and post- disposition situations, and types of facilities.

1. Held for Care, Protection or Best Interest

A juvenile who is in a detention center due to care, protection or in the best interest of the child can be eligible for full benefit Medicaid or Family Access to Medical Insurance Security (FAMIS) coverage.

2. Held for Criminal Activity

a. Prior to Court Disposition

The following juveniles can be eligible for Medicaid payment limited to services received during an inpatient hospitalization.

G. Probation, Parole, Conditional Release, Furlough

An individual released from prison or jail on probation, parole, or release order, with a condition of:

- home arrest
- community services
- outpatient treatment
- inpatient treatment (not inpatient hospitalization)

is not an inmate of a public institution and may be eligible for Medicaid.

An individual released from prison or jail under a court order due to a medical emergency, medical treatment, or pregnancy is NOT an inmate of a public institution and may be eligible for Medicaid.

An individual released from a correctional facility on furlough, for example during a pregnancy, is not an inmate of a public institution while furloughed and may be eligible for Medicaid.

For an offender sentenced to the DOC Community Corrections Alternative Program (CCAP) refer to M0280.140.A

H. Juvenile in Detention Center Due to Care, Protection, Best Interest

A minor in a juvenile detention center prior to disposition (judgment) due to care, protection or the best interest of the child (e.g., Child Protective Services [CPS]), if there is a specific plan for that child that makes the detention center stay temporary, is NOT an inmate of a public institution and may be eligible for Medicaid.

This could include a juvenile awaiting placement but who is still physically present in the juvenile detention center.

I. Juvenile on Probation in Secure Treatment Center

A minor placed on probation by a juvenile court and placed in a secure treatment facility is NOT an inmate of a public institution and may be eligible for Medicaid.

J. Juvenile On Conditional Probation

A minor placed on probation by a juvenile court with, as a condition of probation, treatment in a psychiatric hospital or a residential treatment center, or treatment as an outpatient may be eligible for Medicaid.

However, if the minor is NOT on probation but is ordered to the treatment facility, he remains an inmate of a public institution and not eligible for full benefit Medicaid. He may be eligible for Medicaid coverage limited to inpatient hospitalization.

K. Juvenile On Probation in Secure Treatment Center

A minor placed on probation by a juvenile court and placed in a secure treatment facility may be eligible for Medicaid.

Changed With	Effective Date	Pages Changed
TN #DMAS-26	1/1/23	Pages 2, 28b Appendix 1
TN #DMAS-24	7/1/22	Page 36 Page 37 is a runover page.
TN #DMAS-23	4/1/22	Pages 2, 5, 6, 6a
TN #DMAS-22	1/1/22	Page 28
TN #DMAS-20	7/1/21	Page 6 Pages 5 and 5a are runover pages.
TN #DMAS-18	1/1/21	Table of Contents, page ii Pages 26, 27 Appendix 1 was removed. Appendix 2 was renumbered to Appendix 1.
TN #DMAS-17	7/1/20	Page 7 Pages 8 and 9 are runover pages.
TN #DMAS-15	1/1/20	Pages 29, 30
TN #DMAS-14	10/1/19	Pages 24, 26, 27, 40
TN #DMAS-13	7/1/19	Pages 24 Page 24a is a runover page.
TN #DMAS-12	4/1/19	Pages 8, 9, 13
TN #DMAS-10	10/1/18	Table of Contents, page ii Pages 1-4 Page 40 was added.
TN #DMAS-9	7/1/18	Page 35 Appendix 2, Page 1
TN #DMAS-8	4/1/18	Page 9
TN #DMAS-7	1/1/18	Pages 34, Appendix 2, page 1
TN #DMAS-5	7/1/17	Pages 13, 37, 38
TN #DMAS-4	4/1/17	Pages 24, 30a Page 23 is a runover page. Page 24a was added as a runover page.

M0310.002 LIST OF MEDICAID COVERED GROUPS

Group and Description Mandatory = required under federal regulations Optional = State Plan Option		**Categorically Needy (CN)**	**Medically Needy(MN)**
Aged, Blind, or Disabled (ABD)	SSI – mandatory	**X**	
	AG – mandatory	**X**	
	Protected – mandatory	**X**	
	≤ 80% FPL – optional	**X**	
	≤ 300% of SSI – optional (institutionalized only)	**X**	
	Medicaid Works – optional	**X**	
	Medicare Savings Programs (QMB, SLMB, QI, QDWI) --all mandatory	**X**	
	Aged Blind Disabled --all optional		**X**
Families & Children (F&C) `	IV-E Foster Care or Adoption Assistance - mandatory	**X**	
	LIFC Parent/Caretaker Relatives - mandatory	**X**	
	Pregnant woman/newborn child – mandatory	**X** mandatory	**X** optional
	Child under age 19 – mandatory	**X**	
	BCCPTA – optional	**X**	
	Plan First – optional	**X**	
	Child under 18 – optional		**X**
	Individuals under age 21, Adoption Assistance Children with Special Needs for Medical or Rehabilitative Care Adoption Assistance	**X** optional	**X** optional
	Former Foster Care Children under age 26 – mandatory (effective January 1, 2014)	**X**	
	MAGI Adults – optional (effective January 1, 2019)	**X**	

The levels of administrative review are in the following order:

a. reconsideration,
b. the hearing before an administrative law judge (ALJ), and
c. the Appeals Council

For example: An individual is enrolled in Medicaid as disabled. However, his SSA claim is denied at the ALJ hearing level. If the individual fails to appeal the ALJ decision to the Appeals Council and the Appeals Council does not decide on its own to review the case, the ALJ decision becomes the final decision once the 60-day deadline for requesting further review has passed. Because the individual no longer meets the disabled definition for another covered group, his Medicaid coverage must be canceled.

2. **RRB Denial, Termination and RRB Appeal**

If RRB denies disability, the disability definition is not met. If the individual has been enrolled in Medicaid as disabled and is not eligible in another covered group, send an advance notice to the recipient to cancel Medicaid.

Persons who believe that their claims have not been adjudicated correctly may ask for reconsideration by the Board's Office of Programs. If not satisfied with that review, the applicant may appeal to the Board's Bureau of Hearings and Appeals. Further, if the individual timely appeals the RRB disability decision, Medicaid coverage must be reinstated until the final decision on the RRB appeal is made. The individual must provide verification that he filed a timely appeal with RRB and must provide verification of the decisions made at all levels of appeal in order for Medicaid to continue during the process.

3. **Subsequent SSA/SSI Disability Decisions**

If the individual appeals a disability denial and the decision is subsequently reversed, reopen and re-evaluate the denied Medicaid application as long as the disability onset month is prior to the month of application or is no later than 90 days after the month of application. If the individual has moved to another locality in Virginia, it is the responsibility of the agency that processed the application to reopen the application and determine eligibility prior to transferring the case. See M1510.104.

M0310.113 RESERVED

M0310.114 FAMILIES & CHILDREN (F&C)

"Families & Children (F&C)" is the group of individuals that consists of

- children under 19,
- pregnant women,
- specified subgroups of children under age 21,
- *Former Foster Care Children* under age 26 (effective January 1, 2014), and
- parent/caretakers of dependent children under age 18.

Also included in the F&C groups are individuals eligible only for family planning services (Plan First) and participants in BCCPTA.

Disability Determination Services (DDS) Contact Information

Send ALL expedited and non-expedited disability referrals to the DDS Central Regional Office.

DDS Regional Office	Hearing Contacts
Central Regional Office Disability Determination Services 9960 Mayland Drive. Suite 200 Richmond, Virginia 23233 Phone: 800-523-5007 or 804-367-4700 General FAX: 804-527-4523 Expedited FAX: 804-527-4518	Primary Contact (schedule): Jacqueline Fitzgerald 804-367-4838 Backup: Patrice Harris 804-367-4714 Hearings FAX: 804-527-4518

M0320 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-26	1/1/23	Page 11
TN #DMAS-24	7/1/22	Pages 2, 30, 31, 33
TN #DMAS-23	4/1/22	Page 27
TN #DMAS-22	1/1/22	Pages 11, 26a, 27
TN #DMAS-20	7/1/21	Pages 24, 26-29
TN #DMAS-19	4/1/21	Pages 26a, 29
TN #DMAS-18	1/1/21	Pages 11, 22, 26, 27
TN #DMAS-17	7/1/20	Pages 24. 25. 26, 27 Page 26a was added as a runover page.
TN #DMAS-15	1/1/20	Pages 11, 26, 27, 29
TN #DMAS-14	10/1/19	Page 40
TN #DMAS-13	7/1/19	Pages 1, 24-27
TN #DMAS-11	1/1/19	Pages 2a, 11, 35, 37
TN #DMAS-10	10/1/18	Page 1 1a added as a runover page
TN #DMAS-9	7/1/18	Page 2, 17
TN #DMAS-7	1/1/18	Page 2, 3, 4, 11, 26-27.
TN #DMAS-4	4/1/17	Page 26
TN #DMAS-3	1/1/17	Pages 11, 27, 29, 40, 41, 44, 45, 52
TN #DMAS-2	10/1/16	Pages 4, 15, 16, 18, 20, 22, 30, 33, Pages 39- 41, 43-45, 48, 51, 52, 55
TN #DMAS-1	6/1/16	Table of Contents, page i Pages 1, 11, 25-27, 46-49 Page 50 is a runover page.
TN #100	5/1/15	Pages 6, 11, 24, 25-27, 29-30
TN #99	1/1/14	Page 11
TN #98	10/1/13	Pages 1, 54, 55.
UP #9	4/1/12	Pages 11, 26, 32, 34-37, 45, 46, 55
TN #97	9/1/12	Table of Contents Pages 1-56 (all pages)
UP #6	4/1/12	Pages 11, 12, 46a
TN #96	10/1/11	Table of Contents Pages 46f-50b Page 50c deleted
TN #95	3/1/10	Pages 11, 12, 42c, 42d, 50, 53, 69 Pages 70, 71 Page 72 added.
TN #94	9/1/10	Pages 49-50b
UP #3	3/1/10	Pages 34, 35, 38, 40, 42a, Pages 42b, 42f
TN #93	1/1/10	Pages 11-12, 18, 34-35, 38 Pages 40, 42a-42d, 42f-44, 49 Pages 50c, 69-71
UP #2	8/24/09	Pages 26, 28, 32, 61, 63, 66
Update (UP) #1	7/1/09	Pages 46f-48
TN #91	5/15/09	Pages 31-34 Pages 65-68

Note: There was no COLA in 2010, 2011 or 2016.

The Cost-of-living calculation formula
(The formula is the current Title II Benefit divided by the percentage increase to equal the benefit amount before the COLA change):

a. *Current Title II Benefit* = *Benefit Before 1/23 COLA*
8.2 (1/23 Increase)

b. *Benefit Before 1/23 COLA* = Benefit Before 1/22 COLA
1.059 (1/22 Increase)

c. Benefit Before 1/22 COLA = Benefit Before 1/21 COLA
1.013 (1/21 Increase)

d. Benefit Before 1/21/ COLA = Benefit Before 1/20 COLA
1.016 (1/20 Increase)

5. Medicare Premiums

a. Medicare Part B premium amounts:

1-1-23 $164.90
1-1-22 $170.10
1-1-21 $148.50
1-1-20 $144.60
1-1-19 $135.50
1-1-18 $134.00

Note: These figures are based on the individual becoming entitled to Medicare during the year listed. The individual's actual Medicare Part B premium may differ depending on when he became entitled to Medicare. **Verify the individual's Medicare Part B premium in SVES or SOLQ-I if it is necessary to know the premium amount for Medicaid eligibility or post-eligibility purposes.**

b. Medicare Part A premium amount:

1-1-23 $506.00
1-1-22 $499.00
1-1-21 $471.00
1-1-20 $458.00
1-1-19 $437.00
1-1-18 $422.00

Contact a Medical Assistance Program Consultant for amounts for years prior to 2016.

6. Evaluation

Individuals who are eligible when a cost-of-living increase is excluded are eligible.

M0330 Changes
Page 1 of 2

Changed With	Effective Date	Pages Changed
TN #DMAS-24	1/1/23	Page 10
TN #DMAS-24	7/1/22	Pages 1, 2, 15, 18, 29, 31, 32 Page 2a was added as a runover page.
TN #DMAS-23	4/1/22	Table of Contents Pages 1, 2, 5, 7, 8, 29, 37, 39, 40
TN #DMAS-20	7/1/21	Pages 1, 13, 14
TN #DMAS-19	4/1/21	Pages 14, 26
TN #DMAS-14	10/1/19	Pages 1, 2, 10a
TN #DMAS-12	4/1/19	Pages 26, 28
TN #DMAS-11	1/1/19	Pages 1, 2, 12, 14-16, 24, 25
TN #DMAS-10	10/1/18	Table of Contents Page 1-2, 30 Page 10a-b were added as runover pages.

A LIFC child must meet the definition of a dependent child in M0310.111. The adult with whom the child lives must be the child's parent or caretaker-relative, as defined in M0310.107. The presence of a parent in the home does not impact a stepparent's eligibility in the LIFC covered group. Both the parent and stepparent may be eligible in the LIFC covered group. When a parent(s) is in the home, no relative (i.e. caretaker/relative) other than another parent or a stepparent can be eligible for Medicaid in the LIFC covered group.

C. Financial Eligibility

Modified Adjusted Gross Income (MAGI) methodology is applicable to the LIFC covered group. The policies and procedures contained in Chapter M04 are used to determine eligibility for LIFC individuals.

1. Basis For Eligibility ("Assistance Unit")

The basis for financial eligibility is the LIFC individual's MAGI household. See M0430.100.

2. Resources

There is no resource test for the LIFC covered group.

3. Income

The income limits, policies and procedures used to determine eligibility in the LIFC covered group are contained in Chapter M04.

4. Income Exceeds Limit

If the individual's income exceeds the LIFC income limit, the individual is not eligible as LIFC. *Individuals should then be evaluated as MAGI. If over the MAGI limit, LIFC families who have been enrolled in Medicaid for at least three of the past six months and who are no longer eligible due to excess earned income must be evaluated for continued eligibility in LIFC Extended Medicaid. See M1520.400.*Ineligible individuals must be referred to the Health Insurance Marketplace for evaluation for the APTC. Spenddown does not apply to the LIFC income limits.

D. Entitlement

Entitlement to Medicaid as an LIFC individual begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

E. Enrollment

The ACs for individuals in the LIFC covered group are:

- 081 for an LIFC individual in a family with one or no parent in the home;
- 083 for LIFC individuals in a two-parent (including a stepparent) household.

Changed With	Effective Date	Pages Changed
TN #DMAS-26	1/1/23	Page 34
TN #DMAS-25	10/1/22	Pages 5, 15, 16
TN #DMAS-24	7/1/22	Appendix 3 Appendix 5
TN #DMAS-23	4/1/22	Pages 16b, 18, 32 Appendix 1, pages 1-2 Appendix 2, pages 1-2 Appendices 6 and 7
TN #DMAS-21	10/1/21	Pages 3, 15
TN #DMAS-20	7/1/21	Pages 2, 14, 15, 16a, 16b, 19 Appendix 3 Appendix 5 Appendix 8
TN #DMAS-19	4/1/21	Appendix 1, pages 1-2 Appendix 2, pages 1-2 Appendices 6 and 7
TN #DMAS-18	1/1/21	Pages 7, 16a, 18, 19 Page 16 b was added. Page 18a was added as a runover page.
TN #DMAS-17	7/1/20	Pages 15, 16, 16a, 19 Appendices 3, 5, and 8
TN #DMAS-16	4/1/20	Pages 16a, 20 Appendix 1, pages 1-2 Appendix 2, pages 1-2 Appendices 6 and 7
TN #DMAS-15	1/22/19	Pages 16, 16a, 19
TN #DMAS-14	10/1/19	Pages 1, 3, 4, 5, 14, 16, 32, 33 Appendix 8
TN #DMAS-13	7/1/19	Pages 32-34, 36 Appendices 3 and 5
TN #DMAS-12	4/1/19	Pages 2, 3, 5-8, 15-16, 19, 32-37 Page 16a was added as a runover page. Page 37 was removed. Appendices 1, 2, 6, 7, 8
TN #DMAS-11	1/1/19	Pages 8, 15, 32-35 Pages 36 and 37 were added.
TN #DMAS-10	10/1/18	Table of Contents Pages 1-5, 9, 10, 15, 16, 19, 22, 23, 30-32 Appendix 7 Appendix 8 was renumbered. Pages 6-8, 11-14, 17, 18, 20, 21, 24-29, 33-35 are runover pages.

- First, add together income already received for the year. Do not convert the income.
- Next, calculate the projected income for the remainder of the year based on the current monthly income, unless the individual's income is expected to change (e.g. current employment is terminating).
- Add income already received to projected income to obtain the **annual** projected income for the current calendar year.
- Compare the **annual** projected income to the 100% FPL **annual** income limits for the MAGI household size in M04, Appendix 1.
- If the **annual** income is less than or equal to 100% FPL, compare the **annua**l income to the **annual** income limit for the individual's covered group.
- For the individual to be eligible for Medicaid or FAMIS as a result of applying the gap-filling rule, the countable income must be no more than the **annual i**ncome limit for the individual's covered group. The 5% income disregard used for the Medicaid/FAMIS MAGI determination does not apply. See M04 Appendices 2-6 for income limits.

3. Renewals

A renewal of eligibility must be completed in January of the following year and annually thereafter. At the time of initial enrollment, change the renewal date to January of the following year. Evaluate the individual's eligibility using Medicaid/FAMIS MAGI methodology before applying gap-filling methodology. A gap-filling evaluation may not be necessary for future eligibility determinations/renewals since tax dependency status and/or income may have changed.

If a woman who is eligible based on gap-filling methodology is pregnant or in the post-partum period in January, do not complete the renewal until the month in which the 60th day following the end of the pregnancy occurs.

4. Individual Not Eligible Using Gap-filling Methodology

If the individual's household income is determined to be over the Medicaid and FAMIS income limits after the gap-filling rule evaluation **and** he meets a MN covered group, he must be offered the opportunity to be placed on a MN spenddown. *If the individual does not provide the necessary verifications for the gap-filling evaluation the application should be denied.*

A. Example Situation – Coverage Gap and Gap Filling Rule

A 10-year-old child lives with both parents, who are not married, and the child is expected to be claimed as a tax dependent by one parent. His parents apply for the APTC through the federal HIM, which uses tax filers income methodology. The child is determined to not be eligible for the APTC because his countable income is below the lower income threshold (it is too low) for APTC eligibility.

The HIM refers the application to Virginia for a Medicaid/FAMIS eligibility determination. The child meets a tax dependent exception in M0430.100 B.2 (he lives with both parents, is claimed as a tax dependent by one parent, and the parents do not expect to file jointly). The child's eligibility for Medicaid or FAMIS is determined using non-filer methodology. Because he is under 19 and both parents are in his household, the income of both parents is counted. His household income with the 5% FPL disregard is over the limit for both Medicaid and FAMIS.

M0530 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-26	1/1/23	Appendix 1, page 1
TN #DMAS-22	1/1/22	Appendix 1, page 1
TN #DMAS-18	1/1/21	Appendix 1, page 1
TN #DMAS-15	1/1/20	Appendix 1, page 1
TN #DMAS-11	1/1/19	Appendix 1, page 1
TN #DMAS-8	4/1/18	Appendix 1, page 1
TN #DMAS-6	10/1/17	Pages 2, 24, 30
TN #DMAS-3	1/1/17	Appendix 1, page 1
TN #DMAS-2	10/1/16	Pages 23, 24
TN #DMAS-1	6/1/16	Appendix 1, page 1
TN #100	5/1/15	Pages 14, 16, 29, 30 Appendix 1, page 1
TN #99	1/1/14	Appendix 1, page 1
UP #9	4/1/13	Appendix 1, page 1
UP #6	4/1/12	Appendix 1, page 1
Update (UP) #5	7/1/11	Page 14
TN #95	3/1/11	Page 1 Appendix 1, page 1
TN #93	1/1/10	Pages 11, 19 Appendix 1, page 1

Deeming Allocations

The deeming policy determines how much of a legally responsible relative's income is deemed to the applicant/recipient. The allocation amount increases automatically whenever the SSI payment limit increases.

NBD (Non-blind/disabled) Child Allocation

The NBD child allocation is equal to the difference between the SSI payment for two persons and the SSI payment for one person.

SSI payment for couple - SSI payment for one person = NBD child allocation

2023: $1,371 - $914 = $457
2022: $1,261 - $841 = $420
2021: $1,191 - $794 = $397

Parental Living Allowance

The living allowance for one parent living with the child is the SSI payment for one person.

SSI payment for one person = *$914 for 2023*; $841 for 2022; $794 for 2021

The living allowance for both parents living with the child is the SSI payment for a couple.

SSI payment for both parents = *$1,371 for 2023*; $1,261 for 2022; $1,191 for 2021.

Deeming Standard

The NABD (non-age/blind/disabled) spouse deeming standard is the difference between the SSI payment for two persons and the SSI payment for one person.

SSI payment for couple - SSI payment for one person = deeming standard

2023: *$1,371 - $914 = $457*
2022: $1,261 - $841 = $420
2021: $1,191 - $794 = $397

M0810 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-26	1/1/23	Pages 1, 2
TN #DMAS-24	7/1/22	Page 2
TN #DMAS-23	4/1/22	Page 2
TN #DMAS-22	1/1/22	Pages 1, 2, 3
TN #DMAS-20	7/1/21	Page 2
TN #DMAS-19	4/1/21	Page 2
TN #DMAS-18	1/1/21	Pages 1, 2
TN #DMAS-17	7/1/20	Page 2
TN #DMAS-16	4/1/20	Page 2
TN #DMAS-15	1/1/20	Pages 1, 2
TN #DMAS-14	10/1/19	Pages 20, 25, 27 Page 28 is a runover page.
TN #DMAS-12	4/1/19	Page 2
TN #DMAS-11	1/1/19	Pages 1, 2
TN #DMAS-10	10/1/18	Page 2
TN #DMAS-9	7/1/18	Page 2
TN #DMAS-8	4/1/18	Page 2
TN #DMAS-7	1/1/18	Pages 1, 2
TN #DMAS-5	7/1/17	Page 2
TN #DMAS-4	4/1/17	Page 2
TN #DMAS-3	1/1/17	Pages 1, 2
TN #DMAS-2	10/1/16	Page 2
TN #DMAS-1	6/1/16	Pages 1, 2
UP #11	7/1/15	Page 2
TN #100	5/1/15	Pages 1, 2
UP #10	5/1/14	Page 2
TN #99	1/1/14	Pages 1, 2
TN #98	10/1/13	Page 2
UP #9	4/1/13	Pages 1, 2
UP #7	7/1/12	Page 2
UP #6	4/1/12	Pages 1, 2
TN #95	3/1/11	Pages 1, 2
TN #93	1/1/10	Pages 1, 2
Update (UP) #1	7/1/09	Page 2

GENERAL

M0810.001 INCOME AND ELIGIBILITY

A. Introduction

The following sections explain how to treat income in the Medicaid program. This chapter explains how we count income.

B. Policy Principles

1. Who is Eligible

An individual is eligible for Medicaid if the person:

- meets a covered group; and
- meets the nonfinancial requirements; and
- meets the covered group's resource limits; and
- meets the covered group's income limits.

2. General Income Rules

- Count income on a monthly basis.
- Not all income counts in determining eligibility.
- If an individual's countable income exceeds a classification's monthly limit, a medically needy spenddown may be established, if appropriate.

M0810.002 INCOME LIMITS

A. Income Limits

The Medicaid covered group determines which income limit to use to determine eligibility.

1. Categorically Needy

Supplemental Security Income (SSI) and State Supplement (Auxiliary Grant) recipient's money payments meet the income eligibility criteria in the ABD Categorically Needy covered group.

2. Categorically Needy Protected Cases Only

Categorically-Needy Protected Covered Groups Which Use SSI Income Limits		
Family Unit Size	2022 Monthly Amount	*2023 Monthly Amount*
1	$841	*$914*
2	$1,261	*$1,371*
Individual or Couple Whose Total Food and Shelter Needs Are Contributed to Him or Them		
Family Unit Size	2022 Monthly Amount	*2023 Monthly Amount*
1	$561	*$589*
2	$841	*$894*

3. Categorically Needy 300% of SSI

For the covered groups that use the 300% of SSI income limit, all income is counted (even excluded income) when screening at 300% of SSI. Do not count any monies which are defined as "what is not income" in S0815.000.

Family Size Unit	*2022 Monthly Amount*	*2023 Monthly Amount*
1	*$2,523*	*$2,742*

4. ABD Medically Needy

a. Group I	7/1/21 – 6/30/22		7/1/22	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$2,019.02	$336.50	$2,138.14	$356.35
2	2,570.31	428.38	2,721.95	453.65

b. Group II	7/1/21 – 6/30/22		7/1/22	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$2,329.65	$388.27	$2,467.09	$411.18
2	2,868.64	478.40	3,037.88	506.31

c. Group III	7/1/21 – 6/30/22		7/1/22	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$3,028.56	$504.76	$3,207.24	$534.54
2	3,651.15	608.52	3,866.55	644.42

5. ABD Categorically Needy

For:

ABD 80% FPL, QMB, SLMB, & QI <u>without</u> Social Security income; all QDWI; effective 1/18/22

ABD 80% FPL, QMB, SLMB, & QI <u>with</u> Social Security income; effective 3/1/22

All Localities	2021		2022	
ABD 80% FPL	Annual	Monthly	Annual	Monthly
1	$10,304	$859	$10,872	$906
2	13,936	1,162	14,648	1,221
QMB 100% FPL	Annual	Monthly	Annual	Monthly
1	$12,880	$1,074	$13,590	$1,133
2	17,420	1,452	18,310	1,526
SLMB 120% of FPL	Annual	Monthly	Annual	Monthly
1	$15,456	$1,288	$16,308	$1,359
2	20,904	1,742	21,972	1,831
QI 135% FPL	Annual	Monthly	Annual	Monthly
1	$17,388	$1,449	$18,347	$1,529
2	23,517	1,960	24,719	2,060
QDWI 200% of FPL	Annual	Monthly	Annual	Monthly
1	$25,760	$2,147	$27,180	$2,265
2	34,840	2,904	36,620	3,052

M0820 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-26	1/1/23	Pages 30, 31
TN #DMAS-22	1/1/22	Pages 30, 31
TN #DMAS-18	1/1/21	Pages 30, 31
TN #DMAS-12	4/1/20	Page 29
TN #DMAS-15	1/1/20	Pages 30, 31
TN #DMAS-14	10/1/19	Pages 10, 11, 13, 22, 24
TN #DMAS-12	4/1/19	Page 21
TN #DMAS-11	1/1/19	Pages 30, 31
TN #DMAS-7	1/1/18	Page 11, 30-32
TN #DMAS-5	7/1/17	Pages 11, 13, 29, 30 Page 12 is a runover page.
TN #DMAS-3	1/1/17	Pages 30, 31
TN #DMAS-1	6/1/16	Pages 30, 31, 47
TN #100	5/1/15	Pages 30, 31, 47 Page 48 is a runover page.
TN #99	1/1/14	Pages 30, 31
UP #9	4/1/13	Pages 30, 31
Update (UP) #6	4/1/12	Pages 30, 31
TN #95	3/1/11	Pages 3, 30, 31
TN #93	1/1/10	Pages 30, 31
TN #91	5/15/09	Table of Contents Pages 29, 30

3. Other Earned Income

Then, other income exclusions are applied, in the following order, to the rest of earned income in the month:

a. Federal earned income tax credit payments.

b. Up to $10 of earned income in a month if it is infrequent or irregular.

c. *For 2023, up to $2,220 per month, but not more than $8,950 in a calendar year, of the earned income of a blind or disabled student child.*

For 2022, up to $2,040 per month, but not more than $8,230 in a calendar year, of the earned income of a blind or disabled student child.

For 2021, up to $1,930 per month, but not more than $7,770 in a calendar year, of the earned income of a blind or disabled student child.

d. Any portion of the $20 monthly general income exclusion which has not been excluded from unearned income in that same month.

e. $65 of earned income in a month.

f. Earned income of disabled individuals used to pay impairment-related work expenses.

g. One-half of remaining earned income in a month.

h. Earned income of blind individuals used to meet work expenses.

i. Any earned income used to fulfill an approved plan to achieve self-support.

4. Unused Exclusion

Earned income is never reduced below zero. Any unused earned income exclusion is never applied to unearned income.

Any unused portion of a monthly exclusion cannot be carried over for use in subsequent months.

5. Couples

The $20 general and $65 earned income exclusions are applied only once to a couple, even when both members (whether eligible or ineligible) have income, since the couple's earned income is combined in determining Medicaid eligibility.

B. References

For exclusions which apply to both earned and unearned income, see:

- S0810.410 for infrequent/irregular income
- S0810.420 $20 general exclusion
- M0810.430 amount to fulfill a plan for achieving self-support

For exclusions applicable only to earned income, see S0820.510 - S0820.570.

S0820.510 STUDENT CHILD EARNED INCOME EXCLUSION

A. Policy

1. General

For a blind or disabled child who is a student regularly attending school, earned income is excluded under this provision, limited to the maximum amounts shown below.

For Months	Up to per month	But not more than in a calendar year
In calendar year 2023	*$2,220*	*$8,950*
In calendar year 2022	$2.040	$8,230
In calendar year 2021	$1,930	$7,770

2. Qualifying for the Exclusion

The individual must be:

- a child under age 22; and
- a student regularly attending school.

3. Earnings Received Prior to Month of Eligibility

Earnings received prior to the month of eligibility do not count toward the yearly limit.

4. Future Increases

The monthly and yearly limits will be adjusted annually based on increases in the cost of living index. Under this calculation, these amounts will never be lower than the previous year's amounts. However, there may be years when no increases result from the calculation.

B. Procedure

1. Application of the Exclusion

Apply the exclusion:

- consecutively to months in which there is earned income until the exclusion is exhausted or the individual is no longer a child; and
- only to a student child's own income.

2. School Attendance and Earnings

Develop the following factors and record them:

- whether the child was regularly attending school in at least 1 month of the current calendar quarter, or expects to attend school for at least 1 month in the next calendar quarter, and
- the amount of the child's earned income (including payments from Neighborhood Youth corps, Work-Study, and similar programs).

Verify wages of a student child even if they are alleged to be $65 or less per month.

M0830 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-26	1/1/23	Pages 24, 24a, 50
TN #DMAS-24	7/1/22	Page 114
TN #DMAS-23	4/1/22	Page 78
TN #DMAS-17	7/1/20	Page 29
TN #DMAS-12	4/1/19	Page 113
TN #DMAS-7	1/1/18	Table of Contents, page iii, iv. Pages 7-8, 17-18, 20, 29, 48, 79a, 82, 124a-124b, 125.
TN #DMAS-4	4/1/17	Table of Contents, page i Pages 24, 24c
TN #DMAS-2	10/1/16	On page 109, updated the format of the header. Neither the date nor the policy was changed.
TN #DMAS-1	3/23/16	Table of Contents, page iii Pages 18, 82
Update #7	7/1/12	Page 24
TN #94	9/1/10	Page 29
TN #93	1/1/10	Table of Contents, page iv Pages 28, 67, 119-120 Pages 122-125
TN #91	5/15/09	Table of Contents, page i Page 29

SMI premiums for January - March 1987, April - June 1987, and July - September 1987. A Title II check sent in July 1987 includes full benefits for January - June 1987 and refunds SMI premiums for August - September 1987, which will be withheld from future checks. For Medicaid purposes, the part of the check which represents full benefits for January - June 1987 is unearned income in July 1987 and the refunded SMI premiums for August - September 1987 are not income.

4. Retroactive State Buy-In

When a State "buys-in" for Medicare on behalf of an individual, a different amount of Title II income may be posted because of the Title II rounding provisions.

5. Underpay-ments

Title II benefits can be received in regular monthly checks (or by direct deposit) or in retroactive payments. If an individual receives a check because of an underpayment, charge the amount of the check (plus any SMI premiums withheld) as unearned income in the month received; do no look back and allocate an underpayment being made in the current month to prior months. See S0830.010 B. on counting retroactive RSDI benefits for an offset period. See S1120.022 for the treatment of reissued Title II monies in change-of-payee situations.

6. Facility of Payment Provisions

When a Title II auxiliary or survivor beneficiary who is subject to work deductions receives Title II benefits in his name because of the facility (something that makes an operation or action easier) of payment provisions but the benefits are those of other beneficiaries, the amount of Title II benefits of each of the involved beneficiaries must be determined separately. Count the benefits as income to the appropriate beneficiaries.

M0830.211 SPECIAL EXCLUSION OF TITLE II COLA FOR CERTAIN ABD COVERED GROUPS

A. Policy

The cost-of-living adjustment (COLA) in the individual's Social Security Title II benefit is excluded through the month following the month in which the new federal poverty limits (FPLs) are published when determining the income eligibility of an individual in the following ABD covered groups:

- Qualified Medicare Beneficiary (QMB
- Special Low-income Medicare Beneficiary (SLMB),
- Qualified Individuals (QI), and
- ABD with Income ≤ 80% FPL (ABD 80% FPL).

B. Procedure

Exclude the COLA in the individual's SSA Title II benefit until the first day of the second month following the publication month of the new FPL. Local agency staff are notified of the FPL publication *via a broadcast on the VDSS intranet site.*

C. Example

A QMB-only Medicaid recipient with SSA Title II benefits receives a COLA in the benefit payment for January. The worker does not take any action on this change in income until the FPL broadcast has been posted on *the DSS website*. The FPL change is published on January 31, and LDSS are notified by the FPL broadcast posted on February 3. The worker recalculates the enrollee's income for March 1, based on the recipient's increased Title II benefit and the new QMB income limit which was effective January 31.

Note: COLA exclusion pertains to both ongoing and intake cases.

S0830.215 BLACK LUNG BENEFITS

A. Introduction

1. Types of Black Lung Benefits

Black Lung (BL) benefits are paid to miners and their survivors under the provisions of the Federal Mine Safety and Health Act (FMSHA).

Benefits under **Part B** of the FMSHA are paid by the **Social Security Administration** (SSA) and benefits under **Part C** of the FMSHA are paid by the **Department of Labor** (DOL).

2. Payment Dates

In general, Part B benefits are paid on the third of the month while Part C benefits are paid on the fifteenth of the month.

M0830.410 FOSTER CARE

A. Definitions

1. Foster Care

An individual is considered to be in foster care when:

- a public or private nonprofit agency places the individual under a specific placement program; and
- the placement is in a home or facility which is licensed or otherwise approved by the State to provide care; and
- the placing agency retains responsibility for continuing supervision of the need for such placement and the care provided.

NOTE: When determining the eligibility of a child in foster care refer to the Family & Children's Policy. This section (S0830.410) is to be used only when evaluating the eligibility of a provider of foster care when the provider is the applicant.

2. Foster Care Payment

For Medicaid purposes, a foster care payment is a payment made to the provider for the purpose of meeting the needs of the individual in foster care.

NOTE: An agency may make an additional payment to the foster care provider for his or her own use (e.g., an incentive or service payment not intended to support the child). While these two payments may be combined and termed the "foster care payment" by the issuing agency, only the part which is provided to meet the needs of the individual in care is the foster care payment for Medicaid purposes. *This could include payment(s) such as KinGap, the kinship care program, would provide.*

B. Policy

a. Foster Care Provider

- Foster care payments (as defined in A.2. above) are not income to the provider.
- Amounts paid to a provider of foster care in addition to the foster care payment are income to the provider.

C. Procedure

1. Foster Care Payments to Providers of Foster Care

a. **Assume that the payment made to the provider is a foster care payment** (i.e., is to meet the needs of the individual in care) and is not income to the provider, unless there is evidence to the contrary.

b. **If the provider is a Medicaid recipient or deemor and evidence indicates a payment includes additional monies above the foster care payment,** verify the purpose(s) of the payment and the amounts involved using documents in the individual's possession, or regional

M1110 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-26	1/1/23	Page 1
TN #DMAS-22	1/1/22	Pages 1, 2
TN #DMAS-20	7/1/21	Page 16
TN #DMAS-19	4/1/21	Page 16
TN #DMAS-18	1/1/21	Page 2
TN #DMAS-17	7/1/20	Page 1
TN #DMAS-15	1/1/20	Page 2
TN #DMAS-12	4/1/19	Pages 10-10a
TN #DMAS-11	1/1/19	Page 2
TN #DMAS-3	1/1/18	Page 2
TN #DMAS-4	4/1/17	Pages 10, 10a
TN #DMAS-3	1/1/17	Pages 2, 7, 10, 11 Page 10a was added as a runover page.
TN #100	5/1/15	Page 2
TN #99	1/1/14	Page 2
UP #9	4/1/13	Page 2
UP #6	4/1/12	Page 2
TN #96	10/1/11	Page 2
TN #95	3/1/11	Page 2
Update (UP) #3	3/2/10	Table of Contents page 2
TN #93	1/1/10	Page 2
TN #91	5/15/09	Pages 14-16

M1110.003 RESOURCE LIMITS

A. Introduction

The resource limit is the maximum dollar amount of countable assets an individual, couple, or family may own and still meet the established criteria for Medical Assistance in an ABD category. These amounts are established by law.

B. Policy Principles

1. Resource Ineligibility

An individual (or couple) with countable resources in excess of the applicable limit is not eligible for Medicaid.

2. Resource Limits

ABD Eligible Group	One Person	Two People
Categorically Needy Medically Needy	$2,000	$3,000
ABD with Income ≤ 80% FPL	$2,000	$3,000
QDWI	$4,000	$6,000
QMB SLMB QI	**Calendar Year** **2021** $7,970 **2022** $8,400 ***2023*** *$9,090*	**Calendar Year** **2021** $11,960 **2022** $12,600 ***2023*** *$13,630*

3. Change in Marital Status

A change in marital status can result in a change to the applicable resource limit. The resource limit change is effective with the month that we begin treating both members of a couple as individuals. For example, separation from an ineligible spouse can change the limit from $3,000 to $2,000. See M1110.530 B.

4. Reduction of Excess Resources

Month of Application

Excess resources throughout the month of application causes ineligibility for the application month. Reduction of excess resources within the application month can cause resource eligibility for that month.

M1420 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-26	1/1/23	Pages 1 and 2
TN #DMAS-25	10/1/22	Table of Contents Pages 1-5
TN #DMAS-24	7/1/22	Table of Contents Pages 1-5 Appendix 1 Page 6 was removed. Appendix 1 was removed and Appendix 2 was renumbered to Appendix 1.
TN #DMAS-19	4/1/21	Page 2
TN #DMAS-17	7/1/20	Pages 1-6
TN #DMAS-12	4/1/19	Page 2
TN #DMAS-11	1/1/19	Entire subchapter
TN #DMAS-7	1/1/18	Table of Contents Pages 2, 5. Appendix 2.
TN #DMAS-5	7/1/17	Pages 2-6
TN #DMAS-1	1/1/17	Table of Contents Pages 3-6 Appendix 3 Appendices 4 and 5 were removed.
TN #DMAS-1	6/1/16	Pages 3-5 Page 6 is a runover page. Appendix 3, page 1
TN #99	1/1/14	Page 4
UP#7	7/1/12	Pages 3, 4
TN #94	09/01/10	Table of Contents Pages 3-5 Appendix 3
TN #93	01/01/10	Pages 2, 3, 5 Appendix 3, page 1 Appendix 4, page 1

M1420.000 AUTHORIZATION FOR MEDICAID LTSS

M1420.100 MEDICAID LTSS AUTHORIZATION REQUIREMENTS

A. Introduction

Medicaid covers long-term services and supports (LTSS) in a medical facility or community-based setting for individuals whose mental or physical condition requires assistance with activities of daily living. For Medicaid to cover LTSS, the individual must:

- meet the definition of an institutionalized individual in subchapter M1410. The individual's eligibility as an institutionalized individual may be determined when the individual is already in a medical facility at the time of the application, or the individual has been authorized to receive LTSS and it is anticipated that they are likely to receive the services for 30 or more consecutive days. If it is known at the time the application is processed that the individual did not or will not meet the 30 consecutive day requirement, the individual is not to be treated as an institutionalized individual.
- meet all Medicaid non-financial eligibility requirements in Chapter M02;
- be financially eligible based on the policy and procedures in subchapter M1460 for unmarried individuals and married institutionalized individuals without a community spouse or subchapter M1480 for institutionalized individuals with a community spouse; and
- Meet the asset transfer policies in subchapter M1450.

This subchapter describes the LTSS authorization required for the types of LTSS, which are facility-based care, home-and-community-based (HCBS) services covered under a Section 1915(c) waiver, and the Program for All Inclusive Care for the Elderly (PACE).

B. Operating Policies

1. Payment Authorization

An LTSS authorization is needed for Medicaid payment of nursing facility (medical institution), HCBS waiver, and PACE services for Medicaid recipients. The authorization *is not required for* the local DSS to determine financial eligibility using the more liberal rules for institutionalized individuals, including the 300% SSI covered group and the special rules for married institutionalized individuals with a community spouse. *If the individual meets the definition of institutionalization they are evaluated using these rules*. The appropriate authorization document (form or screen print) *or documentation of institutionalization* must be maintained in the individual's case record.

2. Authorization Documents

a. Nursing facility-based care, the Commonwealth Coordinated Care Plus Waiver, and PACE

The Medicaid LTSS Authorization Form, DMAS 96 or the equivalent information printed from the electronic Medicaid LTSS Screening system (eMLS) or the Minimum Data Survey (MDS) can be used to authorize nursing facility-based care, the Commonwealth Coordinated Care (CCC) Plus Waiver, and PACE. The Authorization form certifies the type of LTSS service

If documentation is not available when placement needs to be made, verbal assurance from a screener that the form approving LTSS will be mailed or electronically available is sufficient to determine Medicaid eligibility as an institutionalized individual. This information must be received prior to approval and enrollment in Medicaid as an institutionalized individual.

b. **The Community Living Waiver, Building Independence Waiver, and Family and Individual Supports Waiver**.

The Waiver Authorization System (WaMS) (see M1420, Appendix 3) or Intellectual Disability On-line System (IDOLS) are used to authorize services received under the Community Living (CL) Waiver, Building Independence (BI) Waiver, and Family and Individual Supports Waiver. Copies of the authorization screens *or a 225 Communication form stating services have started* are acceptable.

3. Authorization Not Received

If the appropriate documentation authorizing LTSS is not received, Medicaid eligibility for an individual who is living in the community must be determined as a non-institutionalized individual.

4. Continuing Authorization

Providers re-evaluate the individual's level of care periodically. The authorization for Medicaid payment of LTSS may be rescinded by the physician or by DMAS at any point that the individual is determined to no longer meet the required Medicaid level of care criteria via level of care review process.

When an individual is no longer eligible for a HCBS Waiver service, the EW must re-evaluate the individual's eligibility as a non-institutionalized individual.

When an individual leaves the PACE program and no longer receives LTSS services, the EW must re-evaluate the individual's eligibility as a non-institutionalized individual.

Facilities document the level of care using the Minimum Data Survey (MDS). For an individual in a nursing facility who no longer meets the level of care but continues to reside in the facility, **continue to use the eligibility rules for institutional individuals** even though the individual no longer meets the level of care criteria. Medicaid will not make a payment to the facility for LTSS.

M1420.200 RESPONSIBILITY FOR THE LTSS AUTHORIZATION

A. Introduction

The process for completing the required assessment and authorizing services depends on the type of LTSS.

B. Nursing Facility

In order to qualify for nursing facility care, an individual must be determined to meet functional criteria, have a medical or nursing need and be at risk of nursing facility or hospital placement within 30 days without services. An assessment known as the LTSS Screening is completed by a designated screener. For individuals who apply for Medicaid after entering a nursing facility, medical staff at facilities document the level of care needed using the Minimum Data Survey (MDS). **The Eligibility Worker does not need to see any screening authorization if the individual applying is already a resident of a nursing facility when the Medicaid application is filed.**

M1450 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-26	1/1/23	Page 46
TN #DMAS-25	10/1/22	Page 36
TN #DMAS-17	7/1/20	Page 45
TN #DMAS-15	1/1/20	Page 46
TN #DMAS-14	10/1/19	Pages 19, 41, 42, 46
TN #DMAS-10	10/1/18	Pages 1, 2 Appendix 3, page 2 Page 24a was added back; it was inadvertently removed in a previous transmittal. Page 2a was added as a runover page.
TN #DMAS-9	7/1/18	Page 35-36a, 37-38, 43
TN #DMAS-7	1/1/18	Page 4, 24, 36, 36a, 37, 41, 42 Appendix 1, Page 1.
TN #DMAS-5	7/1/17	Table of Contents Pages 13, 35, 41-44 Page 43a was renumbered. Pages 45 and 46 were added as runover pages.
TN #DMAS-3	1/1/17	Pages 30, 40-42, 44
TN #DMAS-1	6/1/16	Pages 13, 15, 35 Pages 14 and 16 are runover pages.
TN #100	5/1/15	Table of Contents Pages 17-19, 36, 37 Page 35 is a runover page.
TN #99	1/1/14	Page 7, 10, 21
UP #7	6/1/12	Table of Contents Pages 37-43 Page 43a was added.
TN #96	10/1/11	Table of Contents Pages 4-8 Pages 15, 16, 25, 26 Pages 31-38 Page 31a removed.
TN #95	3/1/11	Pages 4, 24, 32, 36, 37, 37a, Pages 39, 42, 43
TN #94	9/1/10	Table of Contents Pages 36-37a, 39-44
TN #93	1/1/10	Table of Contents Pages 3, 17-18, 29 Appendix 2, page 1
TN #91	5/15/09	Pages 41, 42

C. Send DMAS Notice

The agency worker must send a copy of the DMAS-225 to:

Department of Medical Assistance Services
Eligibility and Enrollment Services Division
600 E. Broad St., Suite 1300
Richmond, VA 23219.

Or email to DMASEvaluation@dmas.virginia.gov.
The copy of the DMAS-225 must be signed and dated by the worker, and must show the worker number and the local agency's FIPS code.

Any information the agency receives about the individual's subsequent receipt of compensation which shortens the penalty period must be sent to *DMAS* at the above address.

M1460 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-26	1/1/23	Pages 3, 35
TN #DMAS-24	7/1/22	Pages 11, 47, 48
TN #DMAS-23	4/1/22	Pages 12, 23
TN #DMAS-22	1/1/22	Pages 3, 35
TN #DMAS-18	1/1/21	Pages 3, 35
TN #DMAS-15	1/1/20	Pages 3, 35
TN #DMAS-14	10/1/19	Pages 4, 29
TN #DMAS-13	7/1/19	Page 42
TN #DMAS-11	1/1/19	Pages 3-5, 10, 26, 31
TN #DMAS-10	10/1/18	Table of Contents, page i Pages 1-3, 4b, 5, 6, 9, 10, 13, 15, 17a, 18, 18a, 26, 27, 30a, 37, 38 Pages 8a, 11, 19, 30, 39 and 40 are runover pages.
TN #DMAS-8	4/1/18	Pages 18a, 32, 35
TN #DMAS-7	1/1/18	Pages 3, 7
TN #DMAS-3	1/1/17	Pages 3, 4, 4b, 24, 25, 29
TN #DMAS-2	10/1/16	Page 35
TN #DMAS-1	6/1/16	Table of Contents, page i Pages 3, 8a, 17, 32
TN #100	5/1/15	Table of Contents, page i Pages 1, 2, 5, 6, 10, 15, 16-17a, 25,41-51
TN #99	1/1/14	Pages 3, 35
UP #9	4/1/13	Table of Contents Pages 3, 35, 38, 41, 42, 50, 51
TN #97	9/1/12	Table of Contents Pages 1, 4-7, 9-17 Page 8a was deleted. Pages 18a-20, 23-27, 29-31 Pages 37-40, 43-51 Pages 52 and 53 were deleted
UP #6	4/1/12	Pages 3, 35
TN #96	10/1/11	Pages 3, 20, 21
TN #95	3/1/11	Pages 3, 4, 35
TN #94	9/1/10	Page 4a
TN #93	1/1/10	Pages 28, 35
TN #91	5/15/09	Pages 23, 24

11. Old Bills

Old bills are unpaid medical, dental, or remedial care expenses which:

- were incurred prior to the Medicaid application month and the application's retroactive period,
- were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met, and
- remain a liability to the individual.

EXCEPTION: Bills paid by a state or local program and which meet the definition of "old bills" are treated as old bills even though they are not the individual's liability.

12. Projected Expenses

Expenses for services that have not yet been incurred but are reasonably expected to be incurred are projected expenses.

13. Spenddown Liability

The spenddown liability is the amount by which the individual's countable income exceeds the MNIL for the budget period.

M1460.150 SUBSTANTIAL HOME EQUITY PRECLUDES ELIGIBILITY FOR LTSS

A. Applicability

The policy in this section applies to nursing facility and CBC/PACE patients, including MAGI Adults effective January 1, 2019, who meet the requirements for LTC services, now called long term services and supports (LTSS), on or after January 1, 2006. This includes individuals who filed reapplications after a break in Medicaid eligibility. It does **not apply** to Medicaid recipients who were approved for LTSS prior to January 1, 2006, and who maintain continuous Medicaid eligibility.

For Medicaid applicants or enrollees approved for LTSS on or after July 1, 2006, the amount of equity in the home at the time of the initial LTSS determination and at each renewal must be evaluated.

B. Policy

Individuals with equity value (tax assessed value minus encumbrances) in home property that exceeds the limit are NOT eligible for Medicaid payment of LTSS unless the home is occupied by

- a spouse,
- a dependent child under age 21 years, or
- a blind or disabled child of any age.

If substantial home equity exists, the individual is not evaluated for or eligible for the Medicaid payment of LTSS. Do not evaluate asset transfers.

An individual with excess home equity is not eligible in the 300% of SSI covered group, but may be eligible for Medicaid payment of covered services other than LTSS if he is eligible in another covered group. Evaluate eligibility for an individual with substantial home equity in other covered groups.

***1.* Home Equity Limit**

The applicable home equity limit is based on the date of the application or request for LTC coverage. The home equity limit is:

- Effective January 1, 2021: $603,000
- Effective January 1, 2022: $636,000
- *Effective January 1, 2023: $688,000*

6. Domestic Travel Tickets — Gifts of domestic travel tickets [1612(b)(15)].

7. Victim's Compensation — Victim's compensation provided by a state.

8. Tech-related Assistance — Tech-Related Assistance for Individuals with Disabilities [ref. P.L. 100-407].

9. $20 General Exclusion — $20 a month general income exclusion for the unit.

EXCEPTION: Certain veterans (VA) benefits are not subject to the $20 income exclusion. Refer to subchapter S0830 for complete explanation of which VA payments are entitled to the $20 general exclusion.

10. PASS Income — Any unearned income used to fulfill an SSI approved plan to achieve self-support (PASS). See item 12 below for earned income used to fulfill a PASS [1612(b) (4)(A) & (B)].

11. Earned Income Exclusions — The following earned income exclusions are not deducted for the 300% SSI group:

a. For *2023*, up to *$2,220* per month, but not more than *$8,950* in a calendar year, of the earned income of a blind or disabled student child.

   For 2022, up to $2,040 per month, but not more than $8,230 in a calendar year, of the earned income of a blind or disabled student child.

b. Any portion of the $20 monthly general income exclusion which has not been excluded from unearned income in that same month [1612(b) (2)(A)].

c. $65 of earned income in a month [1612(b) (4)(C)].

d. IRWE - earned income of disabled individuals used to pay impairment-related work expenses [1612(b) (4)(B)].

e. One-half of remaining earned income in a month [1612(b) (4)(C)].

f. BWE - Earned income of blind individuals used to meet work expenses [1612(b) (4)(A)].

g. Earned income used to fulfill an SSI approved plan to achieve self-support (PASS) [1612(b) (4)(A) & (B)].

12. Child Support — Child support payments received from an absent parent for a blind or Disabled child [1612(b) (9)].

M1470 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-26	1/1/23	Pages 19, 20
TN #DMAS-25	10/1/22	Page 20
TN #DMAS-24	7/1/22	Pages 1, 15, 28a, 44, 48-50 Page 14a is a runover page.
TN #DMAS-22	1/1/22	Pages 19, 20
TN #DMAS-21	10/1/21	Page 17
TN #DMAS-20	7/1/21	Pages 11, 20, 26
TN #DMAS-19	4/1/21	Pages 7, 8, 22, 23
TN #DMAS-18	1/1/21	Pages 19, 20
TN #DMAS-17	7/1/20	Table of Contents, page ii Pages 1, 14, 28a, 47, 48, 50, 55 Appendix 1, page 1
TN #DMAS-15	1/1/20	Pages 19, 20
TN #DMAS-14	10/1/19	Table of Contents, page i Pages 1, 14, 28a, 31, 32, 43, 47, 48, 50 Appendix 1, page 2 Page 14a was added as a runover page.

M1470.410 MEDICAID CBC - PERSONAL MAINTENANCE ALLOWANCE

A. Individuals

For the month of entry and subsequent months, deduct from the patient's gross monthly countable income a personal maintenance allowance (PMA). The amount of the allowance depends upon under which Medicaid CBC waiver the patient receives LTC services.

The total amount of the PMA cannot exceed 300% SSI.

1. Basic Maintenance Allowance

Patients receiving Medicaid CBC under the following waivers are allowed a monthly basic PMA:

- Commonwealth Coordinated Care Plus (CCC Plus) Waiver (formerly the Elderly or Disabled with Consumer-Direction Waiver and the Technology-Assisted Individuals Waiver),
- Community Living (CL) Waiver (formerly Intellectual Disabilities Waiver),
- Family and Individual Supports (IS) Waiver (formerly Individual and Family Developmental Disabilities Support Waiver), and
- Building Independence (BI) Waiver (formerly Day Support Waiver).

Individuals enrolled in the Program for All Inclusive Care for the Elderly (PACE) are also allowed the basic PMA.

The PMA is:

- January 1, 2021 through December 31, 2021: $1,311
- January 1, 2022 through December 31, 2022: $1,388
- *January 1, 2023 through December 31, 2023: $1508*

Contact a Medical Assistance Program Consultant for the PMA in effect for years prior to *2021*.

2. Guardianship Fee

Deduct an amount up to 5% of the patient's gross monthly income (including amounts not counted as income and excluded income) for guardianship fees, if the patient has a legally appointed guardian or conservator AND the guardian or conservator charges a fee. The guardianship **filing** fees CANNOT be deducted from the individual's income. Document how it was determined that the guardian/conservator charges a fee and the amount of the fee.

No deduction is allowed if the patient's guardian receives a payment for providing guardianship services from a public agency or organization that receives funding for guardianship services.

No deduction is allowed for representative payee or "power of attorney" fees or expenses.

3. Special Earnings Allowance for Recipients in CCC Plus, CL, IS and BI Waivers

Deduct the following special earnings allowance if the patient is working (the work does NOT have to be part of treatment). The special earnings allowance is deducted from earned income only. Deduct:

a. for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (*$2,742* in *2023*) per month.

b. for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI (*$1,828* in *2023*) per month.

4. Example – Special Earnings Allowance (Using January 2018 figures)

A working patient receiving CCC Plus Waiver services is employed 18 hours per week. His income is gross earnings of $1228.80 per month and SSA of $300 monthly. His special earnings allowance is calculated by comparing his gross earned income ($1128.80) to the 200% of SSI maximum ($1,500.00). His gross earned income is less than 200% of SSI; therefore, he is entitled to a special earnings allowance. His personal maintenance allowance is computed as follows:

$ 1,238.00 CBC basic maintenance allowance
+ 1,128.80 special earnings allowance
$ 2,360.80 PMA

Because the PMA may not exceed 300% of SSI, the PMA for the patient in this example must be reduced to $2,250.00.

B. Couples

The Medicaid CBC waivers do not specify personal maintenance allowances for a married couple living together when both spouses receive Medicaid CBC because each spouse is considered an individual for patient pay purposes. The individual maintenance allowance in section M1470.410 applies to each spouse in a couple when each receives Medicaid CBC.

M1470.420 DEPENDENT CHILD ALLOWANCE

A. Unmarried Individual, or Married Individual With No Community Spouse

For an unmarried Medicaid CBC patient, or a married Medicaid CBC patient without a community spouse, who has a dependent child(ren) under age 21 years in the community:

- Calculate the difference between the appropriate MN income limit for the **child's** home locality for the number of children in the home and the child(ren)'s gross monthly income. If the children are living in different homes, the children's allowances are calculated separately using the MN income limit for the number of the patient's dependent children in each home.
    - The result is the dependent child allowance. If the result is greater than $0, deduct it from the patient's income as the dependent child allowance. If the result is $0 or less, do not deduct a dependent child allowance.

Do not deduct an allowance if the child(ren)'s monthly income exceeds the MN income limit in the child's home locality for the number of dependent children in the home. Do not deduct an allowance for any other family member.

M1480 Changes
Page 1 of 2

Changed With	Effective Date	Pages Changed
TN #DMAS-26	1/1/23	Pages 7, 18c, 66, 69, 70
TN #DMAS-25	10/1/22	Page 66
TN #DMAS-24	7/1/22	Pages 8a, 8b, 13, 50b, 51, 55, 57, 66, 87, 89, 91
TN #DMAS-22	1/1/22	Pages 7, 18c, 66, 69, 70
TN #DMAS-21	10/1/21	Page 66
TN #DMAS-20	7/1/21	Pages 66, 70
TN #DMAS-18	1/1/21	Page 7, 18c, 66, 69, 70, 92
TN #DMAS-17	7/1/20	Pages 8b, 9, 14, 66, 77, 92
TN #DMAS-15	1/1/20	Pages 1, 7, 18c, 66, 69, 70 Page 2 is a runover page.
TN #DMAS-14	10/1/19	Pages 8a, 8b, 12, 15, 16, 18, 20, 21, 30, 32, 51

27. Spousal Share means ½ of the couple's combined countable resources at the beginning of the **first** continuous period of institutionalization, as determined by a resource assessment.

28. Spouse means a person who is legally married to another person under Virginia law.

29. Waiver Services means Medicaid-reimbursed home or community-based services covered under a 1915(c) waiver approved by the Secretary of the United States Department of Health and Human Services.

M1480.015 SUBSTANTIAL HOME EQUITY PRECLUDES ELIGIBILITY FOR LONG-TERM CARE

A. Applicability

The policy in this section applies to nursing facility and CBC/PACE patients, who meet the requirements for LTC services, now called long term services and supports (LTSS), on or after January 1, 2006. This includes individuals who filed reapplications after a break in Medicaid eligibility. It does **not apply** to Medicaid recipients who were approved for LTSS prior to January 1, 2006, and who maintain continuous Medicaid eligibility.

For Medicaid applicants or enrollees approved for LTSS on or after July 1, 2006, the amount of equity in the home at the time of the initial LTC determination and at each renewal must be evaluated. For the purposes of the home equity evaluation, the definition of the home in M1130.100 A.2 is used; the home means the house and lot used as the principal residence and all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed $5,000.

B. Policy

Individuals with equity value (tax assessed value minus encumbrances) in home property that exceeds the limit are NOT eligible for Medicaid payment of long-term care services unless the home is occupied by:

- a spouse,
- a dependent child under age 21 years, or
- a blind or disabled child of any age.

If substantial home equity exists, the individual is not evaluated for or eligible for the Medicaid payment of LTSS. Do not evaluate asset transfers.

An individual with excess home equity is not eligible in the 300% of SSI covered group, but may be eligible for Medicaid payment of covered services other than LTSS if he is eligible in another covered group. Evaluate eligibility for an individual with substantial home equity in other covered groups.

***1.* Home Equity Limit**

The applicable home equity limit is based on the date of the application or request for LTSS coverage. Effective January 1, 2011, the home equity limit is subject to change annually. The home equity limit is:

- Effective January 1, 2021: $603,000
- Effective January 1, 2022: $636,000
- *Effective January 1, 2023: $688,000*

2. Reverse Mortgages

Reverse mortgages **do not** reduce equity value until the individual begins receiving the reverse mortgage payments from the lender.

2. After Eligibility is Established

Once an institutionalized spouse has established Medicaid eligibility as an institutionalized spouse, count only the institutionalized spouse's resources when determining the institutionalized spouse's Medicaid eligibility. Do not count or deem the community spouse's resources available to the institutionalized spouse.

If an institutionalized spouse's Medicaid coverage was cancelled and he reapplies as an institutionalized individual, use only the resources of the institutionalized spouse for his eligibility determination.

M1480.231 SPOUSAL RESOURCE STANDARDS

A. Introduction

This section provides the amounts and the effective dates of the standards used to determine an institutionalized spouse's initial and ongoing resource eligibility. Use the standard in effect on the date of the institutionalized spouse's Medicaid application. Definitions of the terms are found in section M1480.010.

B. Spousal Resource Standard	*$29,724*	*1-1-23*
	$27,480	1-1-22
	$26,076	1-1-21
C. Maximum Spousal Resource Standard	*$148,620*	*1-1-23*
	$137,400	1-1-22
	$130,380	1-1-21

M1480.232 INITIAL ELIGIBILITY DETERMINATION PERIOD

A. Policy

The initial eligibility determination period begins with the month of application. If the institutionalized spouse is eligible for the month of application, the initial eligibility determination period will both begin and end with that month.

After eligibility is established, the usual reporting and notification processes apply. Send written notice for the month(s) during which the individual establishes Medicaid eligibility. VaCMS will generate the "Notice of Patient Pay Responsibility" and it will be sent to the individual or his authorized representative.

M1480.400 PATIENT PAY

A. Introduction

This section contains the policy and procedures for determining an institutionalized spouse's (as defined in section M1480.010 above) patient pay in all covered groups.

B. Married With Institutionalized Spouse in a Facility

For a married long-term services and support (LTSS) patient with an institutionalized spouse in a facility, **NO** amount of the patient's income is deducted for the spouse's needs in the patient pay calculation.

M1480.410 MAINTENANCE STANDARDS & ALLOWANCES

Introduction

This subsection contains the standards and their effective dates that are used to determine the community spouse's and other family members' income allowances. The income allowances are deducted from the institutionalized spouse's gross monthly income when determining the monthly patient pay amount. Definitions of these terms are in section M1480.010 above.

B. Monthly Maintenance Needs Allowance	$2,177.50 $2,288.75	7-1-21 7-1-22		
C. Maximum Monthly Maintenance Needs Allowance	$3,259.50 $3,435.00 *$3,715.50*	1-1-21 1-1-22 *1-1-23*		
D. Excess Shelter Standard	$653.25 $686.63	7-1-21 7-1-22		
E. Utility Standard Deduction (SNAP)	$322.00 $402.00	1 - 3 household members 4 or more household members	10-1-21 10-1-21	
	$374.00 $473.00	1 - 3 household members 4 or more household members	10-1-22 10-1-22	

M1480.420 PATIENT PAY FOR ABD 80% FPL AND 300% SSI INSTITUTIONALIZED SPOUSE

A. Policy

After a 300% SSI or ABD 80% FPL institutionalized spouse has been found eligible for Medicaid, determine his patient pay (post-eligibility treatment of income).

$875 gross earned income
- 75 first $75 per month
800 remainder
÷ 2
400 ½ remainder
+ 75 first $75 per month
$475 which is > $190

His personal needs allowance is calculated as follows:

$ 40.00 basic personal needs allowance
+190.00 special earnings allowance
+ 17.50 guardianship fee (2% of $875)
$247.50 personal needs allowance

2. Medicaid CBC Waiver Services and PACE

a. Basic Maintenance Allowance

For the Commonwealth Coordinated Care Plus (CC Plus) Waiver (formerly the Elderly or Disabled with Consumer Direction Waiver and the Technology-Assisted Individuals Waiver), Community Living (CL) Waiver (formerly Intellectual Disabilities Waiver), Family and Individual Supports (IS) Waiver (formerly Individual and Family Developmental Disabilities Support Waiver), Building Independence (BI) Waiver (formerly Day Support Waiver), or PACE, deduct the appropriate maintenance allowance for one person as follows:

- January 1, 2021 through December 31, 2021: $1,311
- January 1, 2022 through December 31, 2022: $1,388
- *January 1, 2023 through December 31, 2023: $1,509*

Contact a Medical Assistance Program Consultant for the amount in effect for years prior to 2017.

b. Guardian Fee

Deduct the actual fee a guardian or conservator charges, up to a maximum of 5% of the patient's actual gross income (including amounts not counted as income and excluded amounts) for guardianship fees, IF:

* the patient has a legally appointed guardian or conservator AND
* the guardian or conservator charges a fee.

Document how you determined that the guardian/conservator charges a fee and the amount of the fee.

NOTES: No deduction is allowed for representative payee or "power of attorney" fees or expenses. No deduction is allowed if the patient's guardian receives a payment for providing guardianship services from a public agency or organization that receives funding for guardianship services. The guardianship filing fees CANNOT be deducted from the individual's income.

c. Special Earnings Allowance For CCC Plus, CL, IS, and BI Waivers

[EXAMPLE #19 was deleted]

For the CCC Plus, CL, IS, and BI waivers, deduct the following special earnings allowance if the patient is working (the work does NOT have to be part of treatment). The special earnings allowance is deducted from earned income only. Deduct:

- for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (*$2,742* in *2023*) per month.

- for individuals employed at least 4 but less than 20 hours per week, all earned income up to 200% of SSI (*$1,822* in *2023*) per month.

The total of the basic maintenance allowance, the guardianship fee and the special earnings allowance cannot exceed 300% SSI.

EXAMPLE #20: (Using January 2000 figures)

A working patient in the CL Waiver is employed 18 hours per week. He has gross earnings of $928.80 per month and SS of $300 monthly. His special earnings allowance is calculated first:

$ 928.80	gross earned income
- 1,024.00	200% SSI maximum
$ 0	remainder

$928.80 = special earnings allowance

His personal maintenance allowance is calculated as follows:

$ 512.00	maintenance allowance
+ 928.80	special earnings allowance
$1,440.80	personal maintenance allowance

Changed With	Effective Date	Pages Changed
TN #DMAS-26	1/1/23	Pages 15 and 24a
TN #DMAS-24	7/1/22	Pages 1, 3, 10 Pages 2 and 11 are a runover pages.
TN #DMAS-23	4/1/22	Pages 10, 11, 12, 13, 26, 27, 30 Appendix 2, page 1
TN #DMAS-22	1/1/22	Page 14
TN #DMAS-21	10/1/21	Pages 6, 12
TN #DMAS-20	7/1/21	Pages 2, 3. 5. 6, 13, 14 Page 2a is a runover page. Page 6a was added as a runover page
TN #DMAS-19	4/1/21	Appendix 2
TN #DMAS-18	10/1/19	Pages 1, 4, 4a, 5, 11, 13 Content that was inadvertedly deleted in a previous transmittal was restored. No policy was revised.
TN #DMAS-17	7/1/20	Pages 2, 4, 25, 30 Page 3 is a runover page.
TN #DMAS-16	4/1/20	Pages 3, 4, 7, 9 Appendix 2 Pages 3a and 4 were renumbered to pages 4 and 4a. Page 4a is a runover page.
TN #DMAS-15	1/1/20	Pages 8, 8a
TN #DMAS-14	10/1/19	Pages 2, 3, 4, 6a, 8, 9, 10, 13 Page 4a is a runover page. Page 10a was added as a runover page. Page 7a was deleted.
TN #DMAS-13	7/1/19	Page 14

7. Enrollee Requests Cancellation

An enrollee may request cancellation of his and/or his children's medical assistance coverage at any time. The request can be verbal or written. A written withdrawal request must be placed in the case record. A verbal request for withdrawal can be accepted only from the enrollee or case head, or his authorized representative. A verbal request must be documented in the case record with the date and time the withdrawal request was received, the name of the person who made the withdrawal request, and the signature and title of the agency staff person who took the call.

When the enrollee requests cancellation of Medicaid, the local department must send adequate notice using the Notice of Action to the enrollee no later than the effective date of cancellation.

On the notice:

- check the "other" block and list the reason as "Medicaid coverage cancelled at the enrollee's request,"
- include the effective date of cancellation and instruct the enrollee to discontinue using the card after that date, and
- instruct the enrollee to retain the Medicaid card for future use in case coverage is reinstated within the next 12 months (the system will generate a new card after 12 months).

M1520.400 EXTENSIONS OF MEDICAID COVERAGE

A. Policy

Medicaid families may be eligible for an extended period of Medicaid coverage when the family meets all the requirements for the Low Income Families with Children (LIFC) covered group except income.

LIFC families who received Medicaid in three of the last six months and who became ineligible for Medicaid due to increased income from spousal support may be eligible for a four-month extension.

LIFC families who received Medicaid in three of the last six months and who became ineligible for Medicaid due to an increase in earnings may be eligible for a twelve-month extension. Earnings could increase because of a new job, a raise in the rate of pay or more hours are being worked.

Prior to evaluating *the case* for the Medicaid extensions, review the household's eligibility in the *MAGI* covered group*s*. If eligible, update *the* renewal date*(s)*. If *anyone in the household* is ineligible *in a MAGI group*, evaluate eligibility for the Medicaid extensions.

MAGI methodology for the formation of households does not apply to individuals in Extended Medicaid. The family unit policies in M0520 apply to Extended Medicaid.

If a child under 18 is ineligible for FAMIS, the child must be

M1520.500 CASE TRANSFERS

A. Introduction

Applications and ongoing cases are transferred only when the individual retains residence in Virginia.

B. Nursing Facility and Assisted Living Facility (ALF)

When an individual is admitted to a nursing facility or an ALF from a community living arrangement, the case is not transferred, but remains with the Virginia locality in which the individual last lived outside of an institution. Community living arrangements do not include medical facilities, ALFs or group homes with four or more beds.

When an applicant/recipient is discharged from a nursing facility or ALF to a community living arrangement not in the Virginia locality that had responsibility for the individual's case while he was in the nursing facility or ALF, the case is transferred to the new locality.

If the local agencies involved agree the case should remain with the original agency, then the case would not be transferred.

C. Auxiliary Grant (AG)

See M0320.102 regarding a recipient receiving an Auxiliary Grant (AG) and eligible for Medicaid. The approved member's case should be retained by the agency (locality) which is issuing the grant. Eligibility workers should refer to processing guidelines provided by VDSS and DARS.

M18 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-26	1/1/23	Pages 6a, 7 and 8
TN #DMAS-22	1/1/22	Page 8 Page 7 is a runover page.
TN #DMAS-20	7/1/21	Page 7 Page 8 is a runover page.
TN #DMAS-12	04/01/2019	Page 3, 5
TN #11 DMAS -11	01/01/2019	Page 3
TN #DMAS-10	10/1/18	Pages 3-5
TN #DMAS-6	10/1/17	Table of Contents Pages 3-5 Page 6 is a runover page. Page 6a was added.
TN #100	5/1/15	Table of Contents Pages 1-9 Pages 10-17 were deleted. Appendix 1 was removed.
UP #9	4/1/13	Page 3
UP #7	7/1/12	Page 12
TN #96	10/01/11	Pages 3, 4, 16
TN #95	3/1/11	Page 9
TN #94	9/1/10	Page 12
TN #93	1/1/10	Pages 4, 5
TN #91	5/15/09	Page 2 Pages 5, 6 Page 8

M1850.100 COVERED SERVICES

A. General Information

Information on Medicaid covered services is provided to assist the eligibility worker in responding to general inquiries from applicants/recipients. Individuals who have problems with bills or services from providers of care should be referred as follows:

- Refer FFS Medicaid enrollees to the DMAS Recipient Helpline at 804-786-6145. Refer individuals who need assistance with transportation to the DMAS transportation broker at 1-866-386-8331.

- Refer individuals enrolled in managed care to the Managed Care HelpLine at 1-800-643-2273 or directly to their MCO. Individuals in managed care who need assistance with transportation must contact their MCO directly.

B. Copayments

a. Medicaid Enrollees without Medicare

Medicaid covered services *no longer* have a "copayment," which is the portion of the cost of the service for which the recipient is responsible.

b. Medicare Beneficiaries

Medicaid covers the Medicare copayment for individuals with Medicare and full-benefit Medicaid (dual eligibles) and Qualified Medicare Beneficiaries (QMB). However, a provider is allowed to collect the Medicare copayment at the time of service. If the provider requires the individual to pay the Medicare copayment, the individual must be reimbursed or credited the Medicare copayment once the provider receives payment of the Medicaid claim.

C. Covered Services

The services listed below are covered:

- case management services;
- certified pediatric nurse and family nurse practitioner services;
- clinical psychologist services;
- community-based services for individuals with intellectual disabilities, including day health rehabilitation services and case management;
- dental services for children enrolled in Medicaid and FAMIS, pregnant women enrolled in Medicaid, FAMIS MOMS, and FAMIS Prenatal Coverage, and effective July 1, 2021, all other adults with **full** Medicaid benefits.
- *dialysis services;*
- emergency hospital services;
- Early Periodic Screening, Diagnostic and Treatment (EPSDT) services;
- family planning services;
- Federally Qualified Health Center clinic services;
- home and community-based care waiver services (see subchapter M1440);
- home health services: nurse, aide, supplies, treatment, physical therapy, occupational therapy, and speech therapy services;
- hospice services;
- inpatient hospital services;
- Intensive Behavioral Dietary Counseling, for individuals in MEDICAID WORKS;
- intermediate care facility services for the intellectually disabled (ICF-ID);
- laboratory and x-ray services;
- Medicare premiums: Hospital Insurance (Part A); Supplemental Medical Insurance (Part B) for the Categorically Needy (CN) and Medically Needy (MN);

- behavioral health services, including clinic services, outpatient psychiatric services, mental health case management, psychosocial rehabilitation, mental health skill building, therapeutic day treatment for children and adolescents, intensive in-home services for children and adolescents, mental health partial hospitalization, mental health intensive outpatient, assertive community treatment, applied behavior analysis, multisystemic therapy, functional family therapy, mobile crisis response, community stabilization, 23-hour crisis stabilization, residential crisis stabilization unit services, therapeutic group homes and psychiatric residential treatment services.

- nurse-midwife services;

- nursing facility care;

- other clinic services: services provided by rehabilitation agencies, ambulatory surgical centers, renal dialysis clinics, and local health departments;

- outpatient hospital services;

- personal assistance services, for individuals in MEDICAID WORKS;

- physical therapy and related services;

- physician services;

- podiatrist services;

- *pregnancy related services*

- prescribed drugs;

- prosthetic devices;

- Rural Health Clinic services;

- skilled nursing facility services for individuals under age 21 years;

- substance abuse services;

- transplant services;

- transportation to receive medical services; and

- vision services.